

How to Study for Chapter 12 The Economics of Health Care

Chapter 12 introduces some new concepts to allow analysis of the health care industry and the problems for the United States that exist in health care.

1. Begin by looking over the Objectives listed below. This will tell you the main points you should be looking for as you read the chapter.
2. New words or definitions and certain key points are highlighted in italics and in red color. Other key points are highlighted in bold type and in blue color.
3. You will be given an In Class Assignment and a Homework assignment to illustrate the main concepts of this chapter.
4. There are several new words in this chapter. Be sure to spend time on the various definitions. There are no new graphs.
5. The teacher will focus on the main technical parts of this chapter. You are responsible for the cases and the ways by which each case illustrates a main principle.
6. When you have finished the text, the Test Your Understanding questions, and the assignments, go back to the Objectives. See if you can answer the questions without looking back at the text. If not, go back and re-read that part of the text. When you are ready, take the Practice Quiz for Chapter 12.

Objectives for Chapter 12 The Economics of Health Care

At the end of Chapter 12, you should be able to answer the following questions:

1. What are the main problems facing American health care?
2. What is Medicare? What is Medicaid?
3. Explain why health care might be different from other industries?
4. What is meant by **“asymmetric information”**? What is **“supplier-induced demand”** and what are its effects?
5. What effects does the existence of health insurance have on the health care industry?
6. In what ways does health care generate externalities?
7. In what ways does health care show the effects of monopoly power?
8. What are the effects of having many health care institutions operate on a non-profit basis?
9. What does it mean that one is **“risk averse”**?
10. What is “comprehensive” health insurance and why is it comprehensive?
11. What is meant by **“adverse selection”** and what are its effects?
12. What is meant by the **“Lemons Principle”** and what are its effects?
13. What is meant by **“moral hazard”** and what are its effects?
14. Explain why health care costs have been rising so rapidly in recent years? Give as many reasons as you can.
15. Explain what is meant by **“fee for service”**. By a **“Preferred Provider Organization” (PPO)**. By a **“Health Maintenance Organization (HMO)**, What are the advantages and disadvantages of each?
16. What is “play or pay”? What is National Health Insurance? What are the advantages and disadvantages of each?

Chapter 12: Evaluation of Markets --The Economics of Health Care

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Introduction

The problems of health care have become major political issues in the United States. When President Clinton was elected in 1992, he announced that the First Lady would be in charge of drafting a health care reform. A proposal was put forward, generating considerable criticism and many counterproposals. When the Clinton proposal failed to pass Congress in 1993, it represented the most significant defeat for the Clinton administration. The issue emerged again in the early 21st century as the cost of health care soared. Several major strikes, including one of grocery workers in 2003, involved the high cost of health care. Companies want workers to pay more of the cost of health care insurance while the workers want the companies to continue paying the cost.

Our purpose here is to examine health care as one important way of evaluating market economies. In the United States, most products are simply bought and sold on free markets. **Is there something different about health care so that government needs to be involved? If so, then exactly in what ways should government be involved?** As you can imagine, there is great disagreement as to the answers to these questions. In this chapter, we will first examine the problems of the American health care system. Second, we will consider why health care might be different from other goods or services and therefore might need government involvement. Finally, we will examine some of the proposals that have been made to improve the health care system.

The Problems of the American Health Care System

There are several health care issues that have sparked this push for reform. **First is the enormous increase in the cost of health care.** Total health care spending in the United States is approaching \$2 trillion. Health care spending has been rising at a faster rate than spending on anything else. Of every six dollars an American today spends buying anything, approximately one dollar is spent on health care. For each person, Canada spends only 70% of what Americans spend on health care. Germany and Japan spend only about half of what Americans spend on health care. And Great Britain spends only about one-third of what Americans spend on health care. Yet, although Americans spend more per person on health care than these other countries, there is no evidence that Americans are healthier. Infant mortality is higher in the United States than in these other countries while expectation of life at birth is about the same.

A second issue results because many people lack the ability to pay for health care. Because health care is so costly, most people have some form of health insurance to help make the payments. In the United States, the most common forms of health insurance are (1) health insurance provided by one's employer, (2) **Medicare** for people at least age 65, and (3) **Medicaid** for people on welfare and with certain disabilities (called MediCal in California). These are discussed more fully below. Many people do not meet any of these criteria. **It has been estimated that over 40 million people (about 15% of the American population) have no access at all to health insurance.** These people can receive emergency treatments at public hospitals. But they do not have access

to the other kinds of treatments that most Americans can get.

A third issue results because Medicare and Medicaid are provided by the government. As the costs of these programs rose so fast, government spending increased faster than expected contributing to the continuing federal budget deficits.

It will be extremely hard to reduce the current budget deficits unless Medicare and Medicaid are reformed to reduce the growth in spending.

A related issue is that rising health care costs have caused rising health insurance premiums for employers. For those companies that do provide health insurance coverage (usually the larger companies), the rise in health insurance premiums has meant that **their costs of production are increasing**, reducing their ability to compete internationally. This is especially likely to be true if their competition comes from Japan or Europe, where health care costs are much lower. Many employers do not provide health insurance at all or replace full-time workers with temporary workers (who do not qualify for health insurance benefits). As mentioned earlier, several strikes in 2003 involved attempts by employers to shift the cost of health insurance on to workers. In addition, because many companies do not provide health insurance, or because one cannot move to another health insurance provider if one has a “pre-existing condition”, **many workers have been reluctant to leave jobs that provide good health insurance coverage.** This has harmed the overall economy by preventing people from moving to jobs where their productivity might be greater.

Why Have Health Care Costs Risen So Much?

The cost of health care has been rising very rapidly. Why has this been occurring? In general, for there to have been a rise in health care costs, **the demand for health care must have been rising faster than the supply.** Let us look at each of these individually.

The demand for health care has been rising rapidly for several reasons. ***First, health care is a normal good, with an income elasticity of demand usually estimated to be around 1.0.*** This means that, as incomes rise 10%, the demand for health care rises about 10%. And, of course, incomes have risen greatly in the United States since the end of World War II. ***Second, the price elasticity of demand for most forms of medical care is quite low --- commonly estimated at about 0.2.*** This means that, as the prices of health care services rise, the quantity of health care services demanded falls very little; therefore, total spending on health care will rise. (The low price elasticity of demand for health care is caused by a perceived lack of substitutes by patients, by the fact that many health care services are provided in emergency situations, and by the fact that so many people have health insurance companies to pay much of the cost.) ***Third, the demand for health care has risen as a result of the aging of the population.*** People over age 65 consume three and one-half times as much health care as those between ages 19 and 64. The proportion of the American population over age 65 is about 13% today compared to 9% thirty years ago (and to become an estimated 20% thirty years from now). ***Fourth, some people argue that the demand for health care has risen because of unhealthy lifestyles --- problems related to alcohol, tobacco, drugs, obesity, and lack of exercise.*** ***Fifth, the demand for health care services may have increased simply because the number of doctors has risen.*** This phenomenon results for two reasons. First, most

health insurance companies pay on a *fee-for-service basis*. This means that the doctors and hospitals only receive revenues if they provide health care services; **their revenues rise the more services they provide**. Some studies argue that up to one-third of common medical tests are at least questionable. Second, the amount of health care services provided has increased because of the **large number of medical malpractice lawsuits** and the high amounts given as awards to those who sue and win. Doctors' response to the high number of lawsuits has been to order a large number of tests to insure that no negligence on their part could be found. *Sixth, the demand for health care services may have risen because of the existence of health insurance.* We will discuss health insurance below.

As was mentioned above, the supply of health care services has not increased enough to keep up with the increase in demand. This has occurred for several reasons. *First, there have been some restrictions on the increase in the number of physicians,* although in the past twenty years, the number of doctors has been increasing as a percent of the total population. This is considered below. *Second, although it is hard to measure, some people argue that worker productivity growth has been slow in health care.* This would slow the growth in the supply of health care services. *Third, and most important, there have been tremendous advances in medical technology.* While these advances have done wonders in saving lives and improving the quality of life, **they has been very costly, leading to very large increases in health care costs.** As we know, increases in costs of production shift the supply curve to the left, overcoming any shift to the right that might result from the small increase in the number of doctors and the small improvements in worker productivity. The fact that these medical advances are commonly paid by insurance companies has led to the incentive and the financial means to develop these medical advances. And since these advances are so expensive, they have increased the incentive of individuals to have health insurance (a vicious circle).

It is hard to know exactly which of these factors have been most important in explaining the increase in health care costs. Several studies have been done. *The best guess from these studies is that between one-third and one-half of the increase can be explained by rising incomes, the aging population, the increased insurance coverage, and the low worker productivity growth. The rest is explained by the high cost of the medical advances.*

Test Your Knowledge

Health care costs have been rising very fast. Such costs will rise either because the demand for health care has been rising or the costs of producing health care have been rising (supply falling). Name some reasons that the **demand** for health care might have been rising in recent years. Then name some reasons that the **costs** of producing health care might have been rising in recent years.

Health Insurance

We have seen that health insurance is one of the factors causing the increase in health care costs. Let us examine the health insurance that is provided by employers. For most people under age 65, this is the source of their health insurance.

It is easy to understand why health care is commonly provided through health

insurance. Like automobile accidents, fires, floods, earthquakes, and so forth, **health problems seem to be random events that can cause enormous financial burdens**. A major illness can cause one to incur bills of hundreds of thousands of dollars. People are usually what is called **“risk averse”**. This means that people are usually willing to pay to avoid the risks of such large financial losses. People would rather pay a small amount every month than be faced with enormous medical bills. (Remember from the case on tax incidence in Chapter 7 that workers are likely to pay for their health insurance, even if paid by their employers, either directly or as reduced wages.)

While it is easy to understand why health insurance is provided for major illnesses, it is not easy to understand why health care is provided for minor health care services. We insure our cars for losses due to a major accident but not for changing the oil or the spark plugs. We insure our homes for major damage from fire or earthquake but not for a sink that becomes plugged. Yet in health care, we insure not only for major illnesses but also for blood tests, routine office visits, and so forth. This phenomenon of **comprehensive health insurance** can be explained by the history of health insurance in the United States. Health insurance began in the United States during the Great Depression when, in an effort to be sure they would be paid for their services, doctors created Blue Cross and Blue Shield. During World War II, there were price ceilings placed on wages. In a time of extreme labor shortage, companies who needed workers could not legally raise the wages to attract them. This got around the price ceilings by buying health insurance for their workers (a form of **“gray market”**). Once a few large companies started paying for their workers’ health insurance, the practice spread to most other large companies as a result of the competition for workers. **The phenomenon of comprehensive health insurance coverage is also explained by the nature of the tax law**. Money paid for health insurance is a tax deduction for the employer but is not taxable income for the employee. If my employer pays me \$100 in wages and I spend it for a blood test, the \$100 is fully taxable income to me. If my employer pays for the blood test through health insurance, the \$100 is not taxable income to me. Clearly, I am better off financially if my employer pays for the blood test through health insurance.

Once health insurance was provided by employers, it became important that all workers in a company be covered. Coverage could not be voluntary. The reason for this is what is called **“adverse selection”**. Suppose there are two employees in a company. One is 25 years old and has had no health problems. The other is 60 years old and has had some major health problems. If workers had a choice of being covered by health insurance or receiving higher wages, the 25 year-old would choose the higher wages while the 60 year-old would choose the health insurance. This would mean that health insurance would only cover those likely to have the highest medical bills. The health insurance would not be able to break-even, let alone make a profit, unless health insurance premiums were very high. **The high costs of health insurance can be avoided by spreading the risks among all workers, including those who are likely to need very little health care**. In effect, the healthier people are subsidizing those who are sicker. However, they do not object because they know that, in the future, they could become the ones who are seriously ill.

Adverse selection is an example of what is called *asymmetric information*. This means that one party to a transaction has better information available to it than does the other party to the transaction. In this example, workers are generally able to predict their own needs for health care better than are outsiders. Because they are, letting people buy their health insurance in a market, as we do for automobile insurance and life insurance, is not desirable. Suppose that we did all buy health insurance in a market. Let's say the price is \$300 per month. Those who are healthy and expect to be healthy might decide that, if they paid for health care out of pocket, they would not spend \$300 per month. So they do not buy health insurance. The health insurance now covers only people who expect to spend more than \$300 per month on health care. The insurance company would operate at a loss unless it raised its premium --- let's say to \$400 per month. Now, those who believe they will spend more than \$300 per month but less than \$400 per month on health care will stop buying health insurance. The insurance company is now left only with people who expect to spend more than \$400 per month. This forces the insurance company to raise its premiums again. And so the process continues. This phenomenon has been named the *"Lemon's Principle"*. When the buyers know more about the need for the service than the sellers, only the lemons (those who are sickest) will be left.

While the phenomenon of health insurance can be explained, it does lead to inefficiencies in the provision of health care. One type of inefficiency has been called *"moral hazard"*. **Moral hazard occurs when a person can unexpectedly raise the costs to the insurance company because the company cannot fully monitor the person's behaviors.** First, the existence of health insurance lowers the price I pay for health care services. A \$50 visit to my doctor costs me only \$10 (plus the opportunity cost of my time). This lower price encourages me to see my doctor more than I otherwise might if I had to pay the full bill. In addition, I do not question the doctor's prescription for tests or for medications on the basis of price since the price that I pay is very low. *Therefore, the existence of health insurance actually increases the use of health care services.* Second, it can be argued that, knowing that health care is cheap for me, I am less likely to take preventative actions that would lessen my need for health care services. Perhaps I would be more conscious of doing those things that would keep me out of the doctor's office if I had to pay the entire bill? If I go skiing, I might take fewer chances if I knew I would have to pay for any medical services I might require. A student came up with an interesting example of moral hazard. He noted that when he was covered on his parents' health insurance, he thought nothing of diving into the mosh pit. But now that he is on his own, he is more careful. (Another example of moral hazard that has been documented is that, as automobiles become safer, people do tend to drive faster.)

In summary, some historical peculiarities as well as the American tax law have given us the health insurance system that we have. The fact of asymmetric information makes it important that all workers are covered by the health insurance. And moral hazard and the low price paid by the health care consumer can lead to excessive use of health care services. This is one reason why the costs of health care have risen so fast.

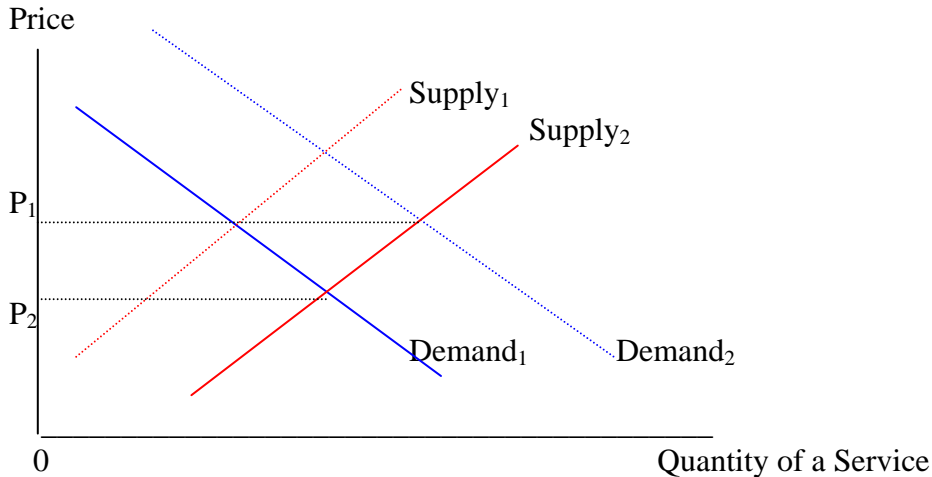
Test Your Knowledge

1. What does it mean that people are **“risk averse”**?
2. Explain why the United States developed a system of **Comprehensive Health Insurance**.
3. What is meant by **“adverse selection”**. Use this term to explain why all employees in a given company need to be covered by health insurance.
4. What is meant by **“asymmetric information”**?
5. What is the **“Lemon’s Principle”**?
6. What is meant by **“moral hazard”**? Use the concept of moral hazard to explain why health insurance may increase the cost of health care.

What is Unique About Health Care?

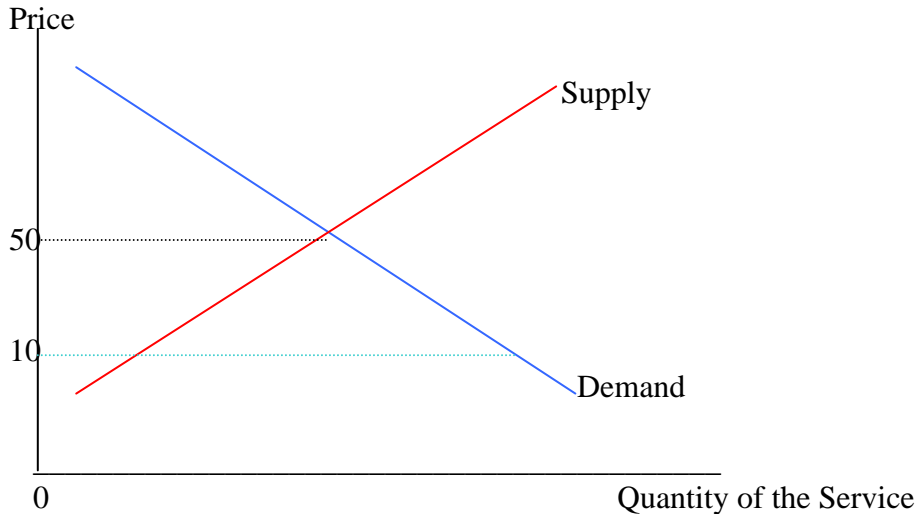
Why is health care not treated as any other product and provided solely through markets? Some people believe that it should be treated as any other product. But most people argue that health care is different from other products in ways that necessitate some kind of government intervention because *health care generates market failures*. Remember from Chapter 10 that market failure means that the markets fail to generate the results that are optimal for society. Let us explore some of these arguments.

One important argument that there are market failures from health care is that the separation between buyer and seller is not maintained for health services. Consider a person seeing a doctor because the person has been experiencing pain. The doctor is clearly the supplier of the services. The person (patient) is the recipient of the services and is the one who initiated the visit. **But it is the doctor (the seller) who decides what services will be provided.** The doctor orders the tests, determines what remedies will be provided, determines how many additional visits the patient must make to the doctor, and so forth. *The market failure here results from “information asymmetry”(see Page 5 above).* A person buying most products is reasonably well enough informed about the product to be able to make his or her own buying decisions. But a patient is not well enough informed to make these decisions about health care treatments. Nor is it conceivable that, without many years of medical training, patients could ever be so informed. Therefore, the patient must rely on the doctor to determine the appropriate treatments. Since the doctor is also the seller, this leads to a conflict of interest. This phenomenon has been called **“supplier-induced demand”**. A common approach to this phenomenon **assumes that doctors have a certain target income**. In the graph below, if the supply of doctors increases from Supply₁ to Supply₂, the price should fall from P₁ to P₂. If there is supplier-induced demand, the doctor merely increases the demand from Demand₁ to Demand₂ to keep the price constant.



For example, the best medical practice may involve rechecking a patient three times a week. If the doctor has many patients, the doctor may decide that it is acceptable to recheck the patient once a week. If the number of doctors has increased and the patient load for each doctor is lighter, the doctor may schedule the patient for rechecking three times a week. The doctor does not see herself as increasing demand; the doctor sees herself as providing the best medical practice. But nonetheless, the doctor has increased demand. A common assertion to support the existence of supplier-induced demand is that the number of surgeries done in a given area seems to be related to the number of surgeons who practice in that area. However, most of the empirical studies to date indicate that the supplier-induced demand effect is smaller today than in the past.

Supplier-induced demand can exist because most patients do not care about the price charged by the doctor (this is one reason that the price elasticity of demand for medical services is so low.). They do not care about the price because they have some form of health insurance. Most health insurance plans require some form of **deductible**. So, for example, I pay the first \$100 of my doctor bills for the year. Also, most health insurance plans require some form of **coinsurance**. Either the patient pays a given percent of the doctor's bill after the deductible has been paid or the patient pays a fixed amount. So if my doctor charges \$50 for a visit, I pay only \$10 and the insurance company pays \$40. ***The market failure here is that the low price paid increases the demand for the service by the patient.*** In the graph below, the price charged by the doctor, the equilibrium price, is \$50 while the price paid by the patient is only \$10.



Raising the price to the patient would accomplish little because the insurance company would pay most of the increase. **The result is a shortage.** In this case, the shortage is resolved in one of two ways. One is for the doctor to determine which patients to see (seller choice). Those with more immediate need will be seen by the doctor while others will be turned away. The other way is to have long lines and long waits to see a doctor (first come, first served). In either case, *the existence of the shortage allows the doctor to be able to increase the demand when the number of doctors increases.*

Yet a third way in which health care generates market failure is that health care involves considerable externalities. The most obvious example of this is that many diseases are communicable. Getting treatment to cure a disease may mean that this disease will not be spread to others. Another example of this has been called a *“caring externality”*. We believe that most diseases seem to strike people randomly. Many people are deeply bothered by the notion that a disease could strike someone and that that person could not obtain treatment. This is true even if we do not know the person involved. For this reason, *health care has become a merit good* (Review Chapter 10).

A fourth market failure of health care results from monopoly power. From the beginning of the 20th century until the 1970s, the supply of doctors was limited by the deliberate policy of the American Medical Association (AMA). To become a licensed physician, one must pass an examination. However, unlike any other profession, in medicine, one must graduate from an accredited medical school to be able to even take the examination. Accreditation was done with great influence from the medical associations. A requirement for a medical school to maintain its accreditation was to limit the number of people admitted. Even today, half of those who apply to medical school and are qualified do not gain admission. The American Medical Association has also been successful at reducing competition to physicians from other health care practitioners, such as chiropractors, optometrists, physicians’ assistants, etc. *The result is that the financial return to “investment” in a medical education is about twice that of “investment” in other form of higher education.*

In addition, in many areas, there is one hospital (or very few hospitals). Because of

the large amount of capital required for a hospital, *the hospital can be seen as an example of a natural monopoly*. A natural monopoly means that, in the normal working of the market, we expect there will be only one supplier. Two or more is not feasible. The reason for this is developed in Chapter 19.

Finally, some pharmaceutical companies are monopolies as providers of drugs for which no close substitute exists.

The final market failure in health care involves the fact that some health care institutions (most hospitals and some health insurance companies) operate as non-profit agencies. We cannot fully examine the theory relating to non-profits here. But review the topic of bureaucracy from Chapter 11. **There it was asserted that the goal of the executives of a bureaucracy is growth (called empire building)**. For hospitals, it is argued that the executive of a hospital will try to maximize the prestige of the hospital and thereby his or her own prestige. This requires owning all of the latest technology. As a result, it is common for several hospitals in a large city to own an expensive machine when there is only demand for one such machine in the entire area. As a result, the machine will be excessively utilized. **It is also argued that, because there is no specific owner, there is less incentive for non-profit hospitals to be cost efficient**. In fact, since the hospital must be non-profit, any “profits” are commonly spent so that they show as costs. For example, what are actually “profits” may be spent as higher salaries or as an expensive new addition to a building. (However, empirical studies tend to show little difference in efficiency between profit and non-profit hospitals.)

In summary, because of supplier-induced demand, because so much of health care is paid by insurance companies, because of the importance of externalities, because there is often monopoly power in health care, and because much of health care is provided by non-profit agencies, one cannot expect to have an optimal result by relying on the pure market alone.

Test Your Understanding

1. The purpose of this chapter is to examine what the health care industry can teach us about markets. We need to understand under what conditions markets should be left free to function on their own and under what conditions government needs to become involved. First, explain why government might need to be involved in the provision of health care. Second, using the justifications for government involvement given in this chapter, **describe exactly what government ought to be doing** to make the health care market work better for society.
2. Recently, there have been some major changes in health care provision. Hospitals that have operated on a non-profit basis (such as Sharp and Palomar-Pomerado) are being taken over by hospital chains whose goal is to maximize profits for shareholders. Health Maintenance Organizations (HMOs) that were non-profit are being joined by new HMOs whose goal is to maximize profits for shareholders. What arguments can you make that these changes are **good for society**? Then, what arguments can you make that these changes are **bad for society**? After considering the arguments on both sides of the issue, do you support or oppose the shift to profit-maximizing institutions? Why?

Recent Health Care Reform Proposals

There have been many proposals to reform the health care system. Reform proposals come under three headings: (1) reforms to lower health care costs, (2) reforms to provide universal access to health insurance and (3) reforms to do both.

(1) Reform Proposals to Lower Health Care Costs

The least radical of the reform proposals to lower health care costs has been to have insurance companies increase deductibles and co-payments by the patient. By raising the cost to the patient, it is believed that patients will be less likely to seek health care. (It is debatable whether this is good or bad.) In addition, insurance companies would not have to pay for many small health care bills, thereby lowering their costs of administration.

A somewhat greater change is the use of **Preferred Provider Organizations (PPOs)**. In this arrangement, health insurance companies make arrangements with a specified group of doctors, hospitals, laboratories, and other providers of health care services. Each of these providers agrees to provide services to patients at a discount. Because of the lower prices paid, the insurance companies can go to a given employer and win the right to insure their employees (by offering a lower cost to the employer). Remember that all employees in the company must be insured. The doctors and hospitals gain from this arrangement because the employees must come to them and cannot use competing services without paying substantially higher prices. Patients lose their choice of physician in this arrangement. However, some PPOs include so many providers of health care that the loss of choice is not a great burden.

More controversial as a health care reform is the use of **Health Maintenance Organizations (HMOs) --- also known as managed care**. Health Maintenance Organizations are not new in the United States; Kaiser-Permanente is the most famous and was created over sixty years ago. To some degree, HMOs are modeled on the National Health Service of Great Britain. San Diego is one of the leading areas in the United States in the proportion of people in some type of managed care. **HMOs eliminate the traditional fee-for-service system. In its place, employers pay a fixed fee for each employee.** The fee is paid regardless of the amount of health care service provided. Doctors who belong to HMOs are often paid a fixed salary, although some HMOs do have a form of profit sharing. Since the fee is paid regardless of the amount of service demanded, **HMOs have an incentive to provide fewer services**. Of course, if they provide too little service, the patient is free to shift to another HMO. If the use of services, such as doctor visits or diagnostic tests, were unnecessary, HMOs will have succeeded in reducing health care costs without harming people's health. But if these were indeed necessary, patients can be harmed. This is the source of most of the controversy concerning HMOs. In addition, if one belongs to an HMO, one can only use the doctors and hospitals associated with that HMO. Indeed, in many HMOs, a patient

cannot see a specialist without first being referred by a General Practitioner. The patient's choices are greatly restricted.

Test Your Understanding

If you have health insurance, do you have fee-for-service, a PPO, or an HMO? If you do not have health insurance, find someone who does. How does your health insurance operate? What do you like about this health insurance? What do you dislike about this health insurance? How much are you (or the other person) paying for this health insurance --- either directly or through an employer?

(2) Proposals to Provide Universal Access

As was noted earlier, a significant number of Americans (well over 40 million) have no access to health insurance. The United States is the only rich, industrial country where this is true. There have been a few proposals to expand access to health care.

The least controversial of these proposals is to provide *a tax credit* so that people who cannot afford to buy health insurance will be able to do so. President George W. Bush has made such a proposal. In effect, the government would be paying for all or part of the health insurance premiums. The main drawback of this proposal was noted earlier --- the high cost of buying individual health insurance policies due to adverse selection.

A proposal of President Clinton was called *“play or pay”*. Most people who do not have access to health insurance work for employers who do not provide it. These people are still able to obtain emergency health care. Since they cannot pay for it themselves, the doctors and hospitals make up for the losses by raising the prices they charge to those who can indeed pay. In effect, those employers who do provide health insurance coverage for their employees are subsidizing those employers who do not. **“Play or pay” would force all employers to either provide health insurance coverage for their employees or to pay into a general fund that would provide health insurance for those presently not covered.** The Clinton proposal ran into considerable political opposition from small businesses and was not passed. However, a law just like this was passed in California in 2003 (to go into effect in 2004). Although there is a challenge to this law, at the time of this writing, all California employers are required to either provide health insurance for their employees or pay into a state fund for health insurance.

(3) Reform Proposals to Lower Health Care Costs and Provide Universal Access

Finally, the most controversial reform proposal is for some type of *National Health Insurance*. Most other industrial countries have this arrangement. The United States also has it for Medicare. **In this proposal, private or non-profit health insurance companies would be replaced by a government agency that would act as a single payer.** The money to pay for this would come from tax revenues and not from health insurance premiums. **(Notice that this is not socialized medicine.** The government does not own the hospitals. Nor do the doctors work for the government. The government's role would only be to pay its part of the bills for a package of basic health care services.) Arguments made by those in favor of this proposal include the following:

(1) all people would be covered, (2) patients would have a free choice regarding any health care provider, (3) the cost of administering the system would be lower than the current system because there would be only one standard claim form and one standard set of rules, (4) employers would not be paying for health insurance, lowering their costs and allowing employees to move more freely between jobs (there might also be less tendency to hire temporary workers just to avoid the health insurance premiums), (5) costs would be reduced through the **monopsony** power of the government (**monopsony means that there is only one buyer** --- the government). If a person is the only seller (monopoly), that person can charge a higher price and get away with it. If a person is the only buyer (monopsony), that person can pay a lower price and get away with it. The government and health care providers would bargain over the fees the government would pay. This type of bargaining is common in Great Britain and Canada.

Despite these arguments, and the fact that health care costs are indeed much lower in countries with a single payer system, National Health Insurance has not gained wide acceptance in the United States. People are afraid that the low prices paid by the government will create shortages --- long waits to obtain basic services. These long waits are commonly found in Great Britain and Canada. Americans also distrust the ability of a government bureaucracy to lower costs (review the Section on Public Choice).

As of 2004, reforms of the health care system have been very modest. A few years ago, one reform allowed employees who lost their jobs to maintain the insurance that had been provided by their employer for a period of time. Of course, they have to pay the health insurance premiums themselves while unemployed. A recent reform allows employees under certain conditions to move their health insurance from one employer to another. Another reform forces insurance companies to stop rejecting people because they have a “pre-existing condition”. One can predict that, in the next few years as the federal government attempts to control health care costs, there will be more reform proposals.

Test Your Understanding

1. In 2004, President Bush’s proposal to reform Medicare was enacted. The main change was that Medicare will pay for part of the cost of prescription medications, beginning in 2006. First, what were the key specific provisions of this 2004 Medicare law? Second, what were the justifications **for** these provisions given by President Bush? Third, what were the arguments made against these provisions by the Democrats in Congress? You can find the answers on the Medicare web site, on the White House web site, on the Democratic Party web site, and in many articles that you can locate by doing a search using Google.

2. In 1993, President Clinton proposed the following reforms (these were not passed into law). What arguments can you make that these changes would have been **good for society**? What arguments can you make that these changes would have been **bad for society**?

- (1) All Americans would be guaranteed a comprehensive health insurance package.
- (2) Individuals and families would receive coverage from a regional or corporate “health alliance”. There would be only one regional alliance in each geographic area, which would cover all people in that area not covered by corporate alliances (which could be formed only by companies with more than 5,000 employees).
- (3) Each regional alliance would provide several plans from which individuals and families would choose. Doctors would be free to choose the plan or plans in which they wish to work. (This is similar to what employers provide their workers today.) All of the plans would

offer the same set of comprehensive benefits. They would differ in the amount people would pay themselves. The plans would be provided by private insurance companies or HMOs, as they are now. The Regional Alliance would only act as a broker between the patient and the plan.

- (4) The premiums would be set by law. For 1994, the average would have been \$1,932 for a single person, \$3,865 for a couple with no children, and so forth. Employers must pay 80% of the average premium. Payments for part-time employees would be pro-rated --- if one worked half time, the payment would be half that of a full-time worker. Self-employed people must make their own payments. The individual or family would have to pay the difference between the employer payment and the premium. If he or she chooses a more comprehensive, and therefore expensive, plan, he or she must pay the difference. If he or she chooses a cheaper plan, he or she can keep the difference. Low-income people would receive discounts on their part of the premium. The government would limit the amount the premium can grow each year.

3. Review the section on price elasticity of demand and tax incidence. Is the incidence of an increase in health insurance premium costs likely to be on the company, on the consumer (as a rise in prices), or on the workers (as a fall in wage increases)? Explain your reasoning.

4. Review the chapter on Public Choice. Then use the material of that chapter to explain why reforms of health care, such as President Clinton's reform proposal or the attempt of Republicans to reduce the growth of Medicare spending, tend to be defeated politically.

Practice Quiz for Chapter 12

1. Health care is an industry which generates **market failure** because of:
 - a. information asymmetry
 - b. monopoly power
 - c. externalities
 - d. all of the above
2. Health insurance must cover **all** of the employees in a company, not just those who choose coverage, because of:
 - a. hospitals being non-profit
 - b. adverse selection
 - c. supplier-induced demand
 - d. monopoly
3. "a person can unexpectedly raise the costs to the health insurance company because the company cannot fully monitor that person's behaviors" is called:
 - a. moral hazard
 - b. supplier-induced demand
 - c. adverse selection
 - d. Lemon's Principle
4. Health care costs have risen greatly because
 - a. the demand for health care has risen as the population has become older
 - b. the demand for health care has risen as a result of the existence of health insurance
 - c. there have been medical advances that have increased health care costs
 - d. worker productivity growth in health care has been slow
 - e. all of the above
5. An organization that accepts a fixed fee for each employee, regardless of the amount of health care service provided, and pays doctors a salary is called:
 - a. a Preferred Provider Organization (PPO)
 - b. National Health Insurance
 - c. a Health Maintenance Organization (HMO)
 - d. Medicare

Answers: 1. D 2. B 3. A 4. E 5. C